directors of adass
adult social services
West Midlands

An operating model for DoLS in the West Midlands

West Midland DoLS recommended operating model.

Introduction

The following is a suggested model for the optimum operation of DoLS. However, there will be aspects of what is suggested that some Councils are simply unable to follow. Some Councils in the West Midlands commission all assessments from external agencies for example and whilst this is not recommended as an ideal model it is undoubtably an effective model whilst the budget allows it to be operationalised. Other Councils have a mix of substantive and Agency BIAs and some Councils commission their service from other parts of the Council.

Some Councils have substantive teams but minimal admin support and some have small teams and with an optimal amount of admin support. Admin support is key to well structured, effective operation of DoLS systems. Some Councils use their Adult Social Care systems (ASC) to manage all DoLS functions including entering annual data and some have an entirely manual and therefore time-consuming system.

Therefore, some Councils may find elements of the suggested operating model that they can adopt, some may find they can or already do follow most of it and some may have to have further discussions in order to make bigger, wider changes.

It is unlikely at this stage, due to uncertainty around the Liberty Protection Safeguards, that any of the Adult Social Care Providers in the West Midlands are going to make significant changes to their DoLS model, beyond adopting the new forms.

West Midlands

Adult Social Care systems			
Liquid Logic	Mosaic	Eclipse	Care Director
7	3	2	2

The Councils who use Care Director do not have DoLS embedded but rely on spreadsheet detail and admin/ manual input.

Advocacy providers for IMCA vary across the region, but this should not affect the operation of DoLS.

IMCA Advocacy providers				
Voiceability	POhWER	SAT	Onside	Asist
4	5	1	2	2

13 Councils have a substantive team of BIAs.

13 Councils use agency or Independent and in two of these cases they are large contracts with a provider for a set number each month.

4 Also have a Rota of BIAs from social work teams.

Some Councils currently utilise BIAs in carrying out wider functions, for example some operate a Duty System and at least one has merged a wider MCA role within the DoLS Team.

All 14 Councils engage with the Regional DoLS Leads group and all 14 Councils access annual training and occasional shorter training courses.

Introduction to the generic DoLS Process

The following three main areas make up the DoLS process:

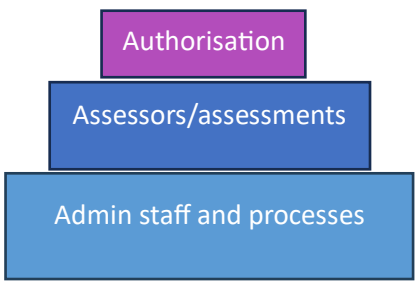
1) **Admin tasks** - which underpin and support. There are numerous tasks specified in the Schedule which admin staff carry out and there are a variety of additional/optional tasks. In general, their role involves most of the following:
    a. Ordinary residence initial checks
    b. Sourcing out of area advocates or representatives
    c. Checking for LPA/Deputy
    d. Communicating with Managing Authorities
    e. Locating and sending other assessments e.g. care and support plans
    f. Allocating to assessors
    g. Sending out and receiving paperwork, including for representative
    h. Ongoing monitoring of conditions
    i. Chasing for return of forms

Some of these tasks can be reduced by the use of electronic forms or use of an Adult Social Care (ASC) portal. Some, such as allocation to assessors, are suitable for other methods. Effective admin systems are key.

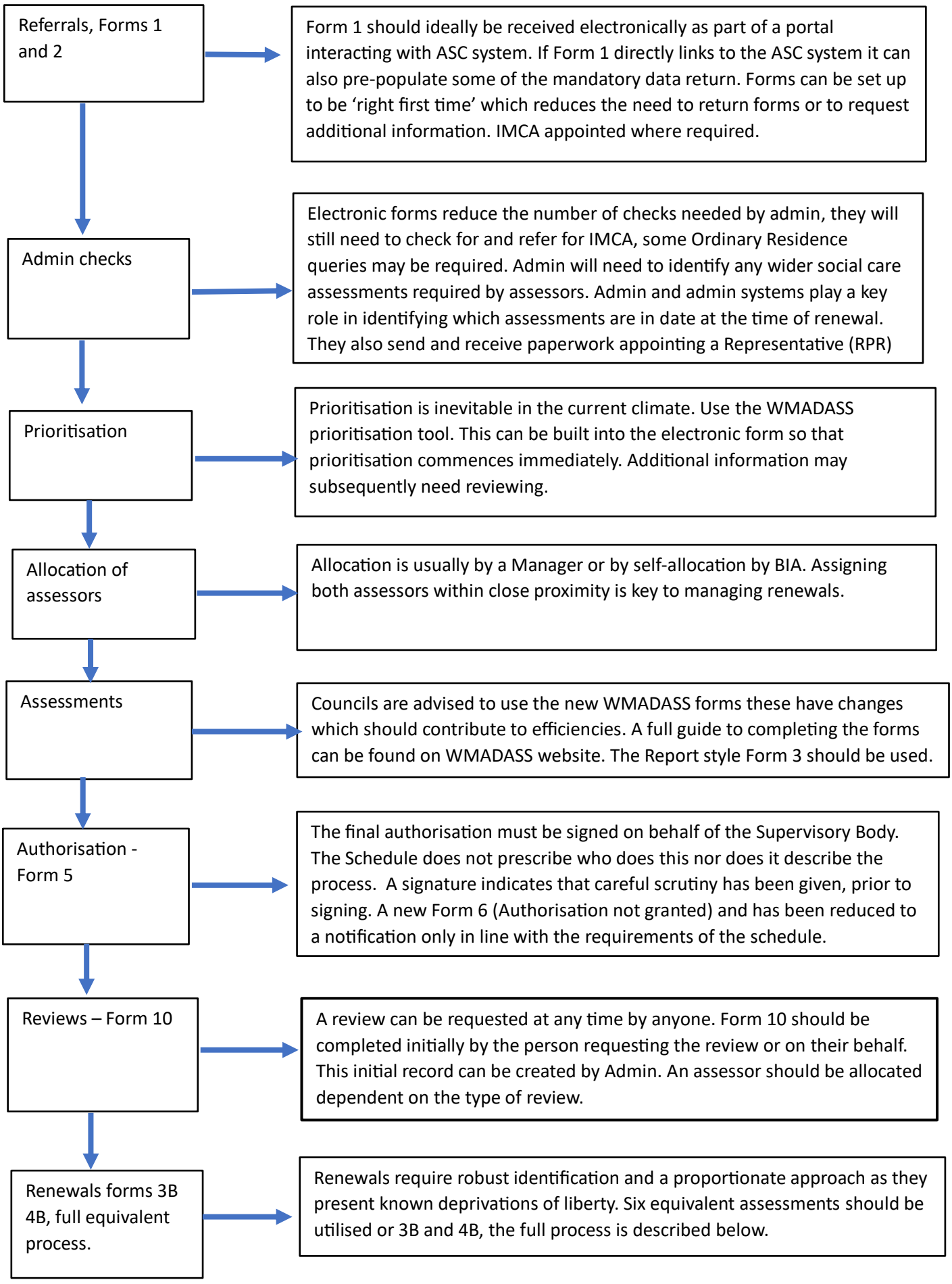
2) **Assessment tasks** – Two assessments determine whether the six requirements are met and recommend length of authorisation and any conditions. The professionals who can carry out assessments are specified in the Schedule and Regulations; the nature and form of assessments are not specified.
    a. **Best Interests Assessor (BIA) carries out mental capacity, best interests, age and no refusals.**
    b. **Doctor as Mental Health Assessor (MHA) carries out mental capacity (if requested) mental health and eligibility.**

Assessments have grown over time to be repetitive, often due to cut and paste by practitioners and in some cases, overly long. They are frequently disjointed and not easily understood by the person, their family, or their representative. There are key elements which must be addressed in assessments and these are specified in the Schedule, which in turn has determined the content of DoLS forms.

3) **Authorisation** – This is the process whereby the Supervisory Body signs an authorisation, having received all the required assessments. It has developed to require scrutiny of the assessments but who carries this role out is not specified. There is no requirement in the schedule for a review of documentation but case law has established that assessments must be scrutinised before signing with a level of scrutiny relevant to the decision.



West Midlands DoLS recommended operating model, in summary



West Midlands DoLS recommended operating model, in detail.

In recommending some changes to process and new ways of working, which are compliant with Schedule A1 of the Mental Capacity Act (MCA), this process also adopts some of the general principles and policy intentions which underpin the Liberty Protection Safeguards (LPS).

Referrals/ requests for authorisation

Form 1 (initial request for new authorisation/and where necessary an Urgent Authorisation)

The ideal is that a Form is received via an online system (web based) or directly through a portal which engages with the ASC system. Forms are prioritised via the system and professional oversight is provided for complex cases or those which have been highlighted by colleagues as needing urgent attention. IMCA referrals will be made as usual using WMADASS form or the providers own form. Ordinary Residence queries should be cut down by the electronic form but complex cases will still need discussion.

Form 2 (further request for authorisation/renewal)

A Form 2 is needed before a renewal process can begin. System driven reminders work best such as reminders to individual BIAs or to an admin team to alert of renewals 28 days before the end of authorisation. This allows the Form 2 to be actively encouraged and ensures the previous assessments are likely to both be in time. The use of a Duty BIA to chase Form 2s is not a proportionate approach nor is doing nothing when renewals are not received. The new Form 2 is shorter and should encourage requests to be sent in but admin systems can be developed to manage this.

Prioritisation (West Midlands/ADASS priority tool)

The WMADASS prioritisation tool will be used but there may be information which is provided subsequently e.g. by social workers which enhances the information given. Regular scrutiny of the backlog should be carried out in order to be aware of the oldest cases as well as the highest priority. It is recommended that admin maintain regular reviews of the backlog data but a BIA or Manager may need input to further prioritisation decisions. Prioritisation should also include a method to ensure older cases and lower priority cases are also assessed. All requests from Acute hospitals must be added to the system and recorded as part of the annual return but will not usually be high priority unless there is evidence to suggest additional risk factors or a length of stay in excess of 14 days or the Council has no backlog.

The use of a Duty BIA to commit time for prioritisation or to maintain contact with Acute hospitals regarding referrals/discharge, reduces their time for assessment and as such is an optional (but not recommended) adjunct to their duties. Their time is to be protected and they should not carry out any functions which could be carried out by admin or other professional staff. The BIA role is a highly specialised role.

Councils who use BIAs in a wider role will need to assess the risks and benefits in relation to the backlog of assessments which cannot be completed by anyone else.

Allocation to assessors and Assessments

Assessors will complete Forms 3 (completed by BIA) and 4 (completed by MHA) . See Guidance to the revised Forms.

Unless there is reason to believe that one of the six requirements may not be met, there should be no delay in allocating assessors and this should be done to the BIA and MHA simultaneously. This then provides the best opportunity for the reuse of assessments subsequently.

There should not be a delay between Form 3 and 4 allocations unless there is uncertainty as to whether the Mental Disorder is met, when a MHA can be requested first.

Councils vary in their opinions as to how many allocations are appropriate but most agree that at least three full Form 3s and an additional number of renewal/review cases can be achieved in a week. With the simplification of some forms in the West Midlands it is hoped that productivity will increase and the expected number of allocations will be higher.

The BIA assessment has been consolidated into one report which should result in better quality as well as some efficiencies of time. West Midlands BIAs should move to using the report style Form 3. MHAs are able to complete a shorter proportionate assessment for renewals a Form 4B.

BIAs and or Doctors will need copies of previous assessments, which can be provided by admin staff.

Authorisation

Authorisation of cases is an area which has spiraled beyond what the schedule (and even the Code of Practice) describes.

There is no description of a full review prior to authorisation, the original intention was that if the assessments are positive then the authorisation is granted. Issues arose when assessments were poor and then also granted with perfunctory scrutiny. So, prior to signing an authorisation there must be some scrutiny, the manner of this is not specified. The scrutiny is about the quality of the two assessments which together establish that the requirements are met, if the quality of either of these is inadequate then they should not be authorised and training needs identified for the assessor.

The Schedule states that there is a Duty to give authorisation if—

(a) all assessments are positive, and

(b) the supervisory body have written copies of all those assessments.

Case law however reminds us (**LB Hillingdon v Steven Neary [2011] EWHC 1377 (COP)**) "*The responsibilities of a supervisory body, correctly understood, require it to scrutinise the assessment it receives with independence and a degree of care that is appropriate to the seriousness of the decision and to the circumstances of the individual case that are or should be known to it. Where, as here, a supervisory body grants authorisations on the basis of perfunctory scrutiny of superficial best interests assessments, it cannot expect the authorisations to be legally valid*."

This West Midlands wide recommended model for DoLS has removed a written record of scrutiny as this is often just a repetition of what is within the assessments but it does not remove the need for careful scrutiny before signing. This returns the form to the original state issued by DHSC at the time.

Authorisers will complete Form 5 (Authorisation granted).

If an authorisation cannot be granted then the scrutiny of an authoriser is not required. Form 6 (Standard Authorisation not granted) gives notice that an authorisation cannot be granted, usually this is due to administrative reasons, e.g. the person has been discharged from hospital. These decisions do

not require greater oversight however on some occasions the assessments will have been carried out and the person is found not to meet one of the requirements, in these cases there may be a need for oversight before issuing a Form 6. It is important to exercise caution before issuing a Form 6 to family where a person has died or been discharged from hospital with no knowledge of an Authorisation being requested.

Representation

A key safeguard of DoLS is the appointment of an IMCA at the beginning of the process if there are no family or friends for the best interests consultation. The scheme also provides for an IMCA at other key points i.e. if there is a break in the cover provided by an RPR or if the person or their RPR require additional support for a discreet period such as making a challenge to the Court of Protection.

Once an authorisation is granted, ongoing support is provided by the RPR. This is a role envisaged for family and friends. However, some people do not have family or friends to appoint, so there is provision within regulations for the SB to appoint someone for the role. It is absolutely essential to note there is no concept of a Paid Relevant Persons Representative (PRPR) although this is a phrase in common usage. There is only an RPR with the facility to pay if necessary. The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Persons Representative) Regulations 2008 merely states (in relation to appointment of an RPR by the SB because there is no one else able to act) 'A supervisory body **may** make payments to a representative appointed following a selection under regulation 9'. The use of the word 'may' means that this is permissive but is not a requirement.

Many Councils originally gave this role to their advocacy providers as an additional duty, this was when numbers were much lower. There is a downside to this in that advocates find it difficult to act as an IMCA one minute, which has some statutory rights and as a RPR the next, which has no statutory rights.

In recent times some Councils have explored the use of volunteers to fill this role. This has two advantages; one of cost (i.e. it is much more economic value) and one of quality (i.e. it provides a greater variety of person and life experience)

Reviews

A request for a review can be made by anyone using Form 10 (Request for review). The SB needs to decide if the grounds for review are met, before commencing a review. The initial record can be created by Admin.

A review can be requested and carried out of conditions alone without a full best interests assessment review being carried out.

In this case a record of the review can be added to a Form 3 without changing any of the other findings.

A full review can be either due to a belief that at least one of the requirements is no longer met or the reason it is met is now different.

It is wise before commencing a review to consider how long is remaining on the authorisation period. A review can only consider the initial authorisation period, it cannot extend it. Therefore, in some circumstances it is better to request a further authorisation i.e. if the request is within 28 days of the end date.

Renewals

Renewals represent those people who are known to be deprived of liberty. This makes them high risk for Councils. However, the size of high priority, new cases may mean that not all renewals can be prioritised. BIAs and MHAs will screen cases for suitability when considering the best route to take for renewals. The process is described below.

The first option to consider for a first renewal is to use all six equivalent assessments. This will require a conversation with the MA to determine there are no significant changes and a conversation with the RPR to discuss the same. This route means that no assessments need be completed but an authorisation is granted again on the basis of the previous assessments. The SB must be satisfied that there is no reason why the existing assessments may no longer be accurate.

Six equivalent process.

Prior to using six equivalents the following should be checked

- There has been at least one previous authorisation granted at the care home, which has not expired.
- The equivalent assessments are current and valid (i.e. the Form 3 and 4 have not expired)
- The renewal must be concluded before the expiry of the previous authorisation.
- The person should ideally have lived in the care setting for a settled period of time and the placement should be stable with no concerns raised by the person's representative (RPR or IMCA)

It is likely that these tasks can be completed by admin staff.

A suitable person, (most likely but not exclusively, a BIA), will speak with the appointed representative or IMCA to seek their views on the authorisation being renewed for a further period without completing new assessments; in particular exploring any changes which would mean the Supervisory Body could not be satisfied that it is appropriate to rely on the previous assessments. Examples might be:

- any increase in restrictions including changes to medication; specifically has antipsychotic medication been applied during the authorisation period,
- any new objections to the care/treatment arrangements,

If the BIA is satisfied, then the deprivation of liberty is authorised according to the usual practice. It is suggested that the Form 5 could have the following addition made by admin -

"*Six equivalent assessments are being used in this authorisation process. The relevant people have been consulted and it is confirmed that all facts remain the same, there has been no change in the person's circumstances which would affect these assessments and so they can be relied on for a further period of authorisation*."

It is important to note that no new forms are completed, it is the previous form 3 and 4 which are authorised for a second period of time.

Proportionate renewals 3B

If this route cannot be taken, perhaps because one of the assessments is now out of time then a proportionate assessment can be carried out by using a Form 3B (a proportionate assessment by the BIA). This is essentially the BIA confirming that there are no changes and that all their conclusions remain as before. A new Form 4 may be required or a 4B (a proportionate assessment by the MHA). Best practice suggests that two 3Bs can be completed before a full Form 3 is required again. The result of this is a three-year authorisation period in line with the LPS proposal.

The use of a 3B suggests that the person is settled in the setting with no challenges made by them or their family/representative. Therefore, before commencing a proportionate assessment, it is wise to check for the following:

- A twelve-month authorisation or a shorter authorisation with no significant conditions set.
- Any significant change highlighted on the Form 2.
- Continued objection by or distress evidenced by the person or their family.
- Continued lack of agreement regarding the care plan.
- Challenging behaviour requiring significant and increasing restrictions.
- New Adult safeguarding concerns.
- A borderline mental capacity assessment.
- Unclear diagnosis or possibility of change.

If an assessment begins as a 3B but issues of concern arise, it should revert to a full form 3.

In the West Midlands we recommend using two 3Bs followed by a full Form 3.

Proportionate renewals 4B

A new Form 4B has been introduced in the West Midlands which mirrors the one in use by BIAs. The Mental Health Assessor should read the previous assessment and have a telephone conversation with the MA. This should enable them to confirm that nothing has changed. The SB will most likely have screened for suitability before allocating but as an independent professional the assessor should be certain that there is no

- significant change indicated which would affect the diagnosis or the persons response to being deprived of liberty.
- Continued objection by or distress evidenced by the person or their family.
- Dispute regarding the diagnosis.
- New challenging behaviour requiring significant and increasing restrictions.
- Unclear diagnosis or possibility of change

As with the 3B if the assessor begins an assessment as a 4B but then determines there are issues of concern, thy should alert the SB and complete a full Form 4.

Sending documentation

1. If an Authorisation is granted the SB must give a copy of the authorisation to each of the following—
    - the relevant person's representative.
    - the managing authority of the relevant hospital or care home.
    - the relevant person.

- any section 39A IMCA.
- every interested person consulted by the best interests assessor.

In practice this means sending the Form 5 to each of the above, ideally assessors should have asked for email addresses and secure email can be used.

2. If the authorisation cannot be granted the SB must give notice of this to each of the following—
    - the managing authority of the relevant hospital or care home.
    - the relevant person.
    - any section 39A IMCA.
    - every interested person consulted by the best interests assessor.

In practice this means sending Form 6, however the Schedule did not anticipate the large numbers of not granted cases where no assessments have been carried out and the person has moved or died. It is not practical or pragmatic to issue a Form 6 in many of these circumstances.

3. The supervisory body must give copies of the assessment to all of the following whether they are positive or not.
    - the managing authority of the relevant hospital or care home.
    - the relevant person.
    - any section 39A IMCA.
    - the relevant person's representative.

    NB: Assessments are not routinely sent to every interested person who has been consulted. This protects the persons dignity and confidentiality of their circumstances.,

4. If the BIA alerts the SB to an unauthorised deprivation of liberty, the SB must notify the following:
    - the managing authority of the relevant hospital or care home.
    - the relevant person.
    - any section 39A IMCA.
    - any interested person consulted by the best interests assessor.

This does **not** mean sending them the BIA assessment but does mean alerting them to an unauthorised deprivation of liberty.

It is good practice to send the Rights Guide which can be found on the WMADASS website to the relevant person.

Quality Assurance

A culture of extended quality assurance has developed over the years. BIAs are experienced, highly skilled professionals and their assessments should reflect this. Proof reading should not be necessary but is often carried out by admin (sometimes there are specific reasons for this due to the needs of the BIA). Councils vary as to whether they will correct a small typo or whether they insist on returning a report to the BIA. Extensive corrections should not be expected or accepted. Team Managers of Seniors who oversee the operation of DoLS will have regular supervision and focus groups for BIAs where quality is addressed.

Some Councils have inserted a role to read and quality assure assessments prior to authorisation which seems to introduce an unnecessary step. Either the person who is quality assuring should also be able to sign the authorisation or the person ultimately signing should be responsible to quality assure as part of their scrutiny.

Issues arising with Independent BIAs regarding the quality of their work should be addressed to either the Agency providing them or directly to the BIA. The Council is paying for a service and should expect the same level of quality as provided by substantive BIAs.

Additional optional duties

Many Councils are utilising BIAs to carry out wider Duty functions. This might involve them in prioritising cases, communicating with care homes, communicating with hospitals, gathering wider information to better prioritise and so on. Whilst all these actions may improve the wider processes it is important to note that only a BIA can carry out the best interests assessment whereas other professionals can carry out wider tasks. Given that the greatest challenge currently is a backlog of assessments then Councils must risk assess the use of BIAs against the potential risks of increasing backlogs.

Conclusions

By adopting the new forms, new Guidance and operating model (in full or in part) supervisory bodies should see improvements in practice and efficiencies which start to impact the backlog.

The following suggestions offer the maximum benefit.

- Electronic or web-based forms.
- Efficient fully staffed admin support.
- Effective systems for identifying renewals.
- Use of pragmatic assessments on renewal.
- Completion of persons centred assessments which provide analysis, reasoning and evidence-based conclusions rather than narrative.

Full guidance to the forms for the West Midlands can be found on the WMADASS website